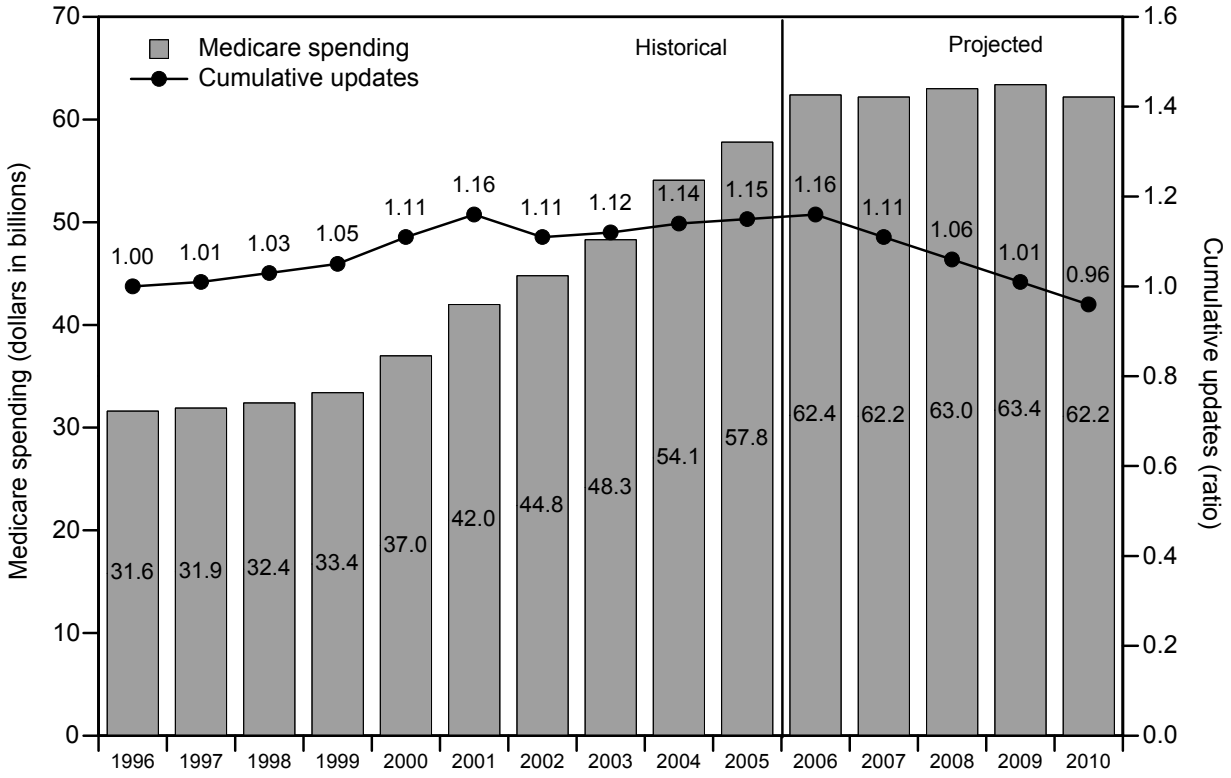
SECTION 8

Ambulatory care

Physicians
Hospital outpatient services
Ambulatory surgical centers
Imaging services

Chart 8-1. FFS Medicare spending and payment updates for physician services, 1996–2010



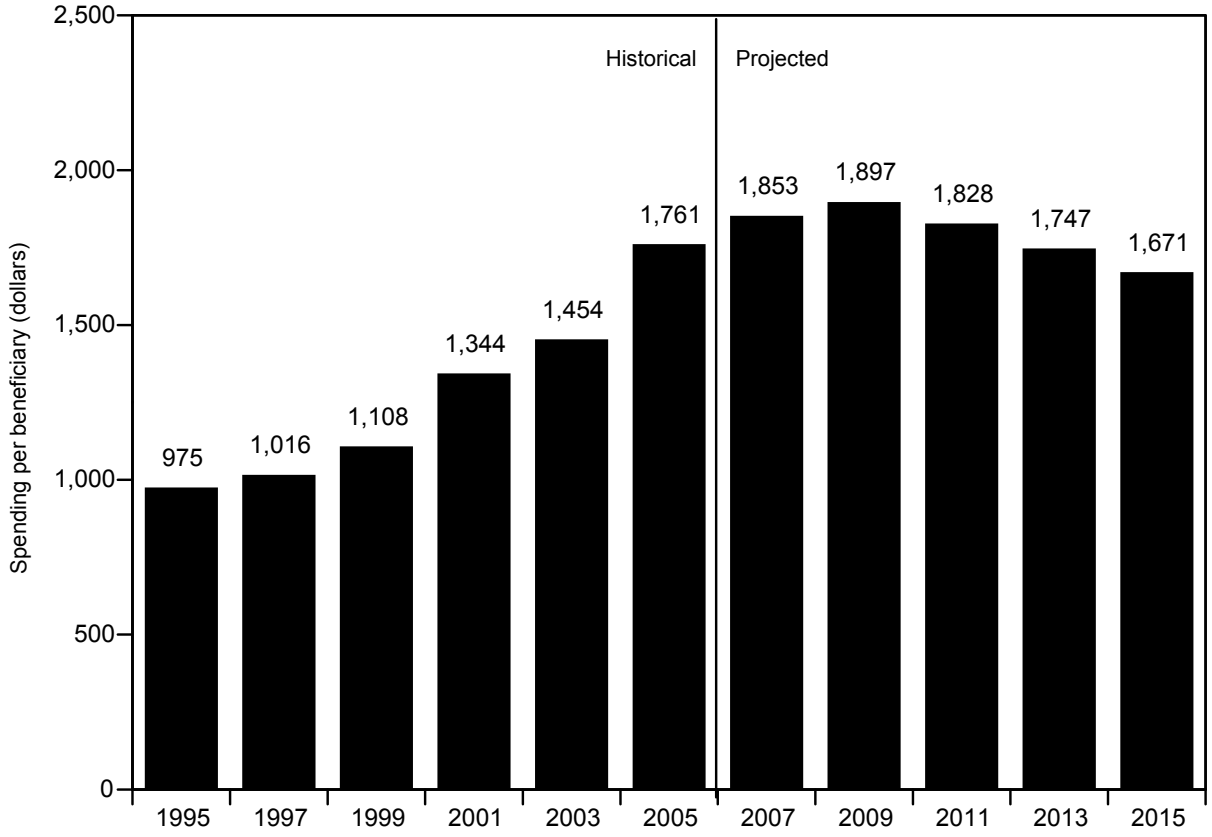
Note: FFS (fee-for-service). Dollars are Medicare spending only and do not include beneficiary coinsurance.

Source: 2006 annual report of the Boards of Trustees of the Medicare trust funds.

- Between 1996 and 1999, Medicare spending on physician services was relatively flat. More rapid growth occurred between 1999 and 2005—averaging almost 10 percent annually.

- The sustainable growth rate system (SGR) requires that future payment increases for physician services be adjusted for past actual physician spending relative to a target spending level. To avoid reductions in 2004 and 2005 physician fee schedule rates due to the SGR, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established minimum payment updates for physician services of 1.5 percent for 2004 and 2005. For 2006, the Deficit Reduction Act froze the physician fee schedule conversion factor. This freeze, combined with refinements to the relative value units, results in an update of 0.2 percent for 2006. Under current law, payments for physician services are slated to decline about 5 percent for nine consecutive years, beginning in 2007.

Chart 8-2. Medicare spending per FFS beneficiary on physician services, 1995–2015



Note: FFS (fee-for-service). Dollars are Medicare spending only and do not include beneficiary coinsurance.

Source: 2006 annual report of the Boards of Trustees of the Medicare trust funds.

- Fee-for-service (FFS) physician spending per beneficiary has increased annually since 1995.
- Under current law, FFS Medicare payments for physician services per beneficiary are projected to decline beginning in 2007 because of scheduled negative payment updates. The volume of physician services per beneficiary, however, is expected to continue to grow.

Chart 8-3. Number of physicians billing Medicare is increasing steadily, 1999–2004

	Number of Medicare patients in caseload			
	≥15	≥50	≥100	≥200
Number of physicians				
1999	432,355	386,720	338,344	261,218
2000	444,187	398,905	351,012	274,059
2001	457,292	411,424	364,023	286,862
2002	466,299	419,269	370,144	291,593
2003	470,213	424,684	374,721	292,183
2004	483,945	440,462	393,730	315,398
Percent growth, 1999–2004	11.9%	13.9%	16.4%	20.7%
Physicians per 1,000 beneficiaries				
1999	11.7	10.4	9.1	7.1
2000	11.9	10.7	9.4	7.3
2001	12.1	10.9	9.7	7.6
2002	12.3	11.0	9.8	7.7
2003	12.3	11.1	9.8	7.6
2004	12.5	11.3	10.1	8.1

Note: Calculations include physicians (allopathic and osteopathic). Nurse practitioners, physician assistants, psychologists, and other health care professionals are not included in these calculations. To calculate the ratios, Part B enrollment is used, which includes beneficiaries in fee-for-service Medicare and Medicare Advantage, on the assumption that physicians are providing services to both types of beneficiaries. To calculate physicians' Medicare caseload size, only fee-for-service beneficiaries are included.

Source: MedPAC analysis of Health Care Information System, 1999–2004, from CMS.

- The number of physicians providing services to beneficiaries has more than kept pace with growth in the beneficiary population. From 1999 to 2004, the number of physicians who billed Medicare grew faster than Medicare Part B enrollment. During this time Part B enrollment grew 4.8 percent, while the number of physicians with at least 15 Medicare patients grew by 11.9 percent. The number of physicians with 200 or more Medicare patients grew even faster at 20.7 percent. This difference in growth rates led to an increase in the number of physicians per 1,000 beneficiaries, from 11.7 to 12.5.

- The participation rate—that is, the percentage of physicians who can bill Medicare and who agree to accept assignment on all claims for payment during a year—has risen steadily over the past decade, reaching 92 percent in 2005.

- When physicians accept assignment, they accept Medicare's fee schedule amount as the service's full charge (of which 20 percent is beneficiary coinsurance). In 2004, 99 percent of allowed charges for physician services were assigned.

Chart 8-4. Spending growth varies by type of service, 2004−2005

Types of Services	Percent of spending	Spending change
Visits	37%	7%
Procedures	26	9
Imaging	14	16
Laboratory and other tests	12	11
Part B drugs	9	–3
Other	1	20
Total	100	8.5

Note: Other includes supplies and equipment furnished incident to physicians' services and medical nutritional therapy. In both columns of numbers, percentages may not necessarily add to the total, due to rounding. The total spending increase is a weighted average, so the spending increases by type of service do not sum to the total.

Source: Kuhn, H.B., CMS, Letter to MedPAC, April 7, 2006, and unpublished data from CMS.

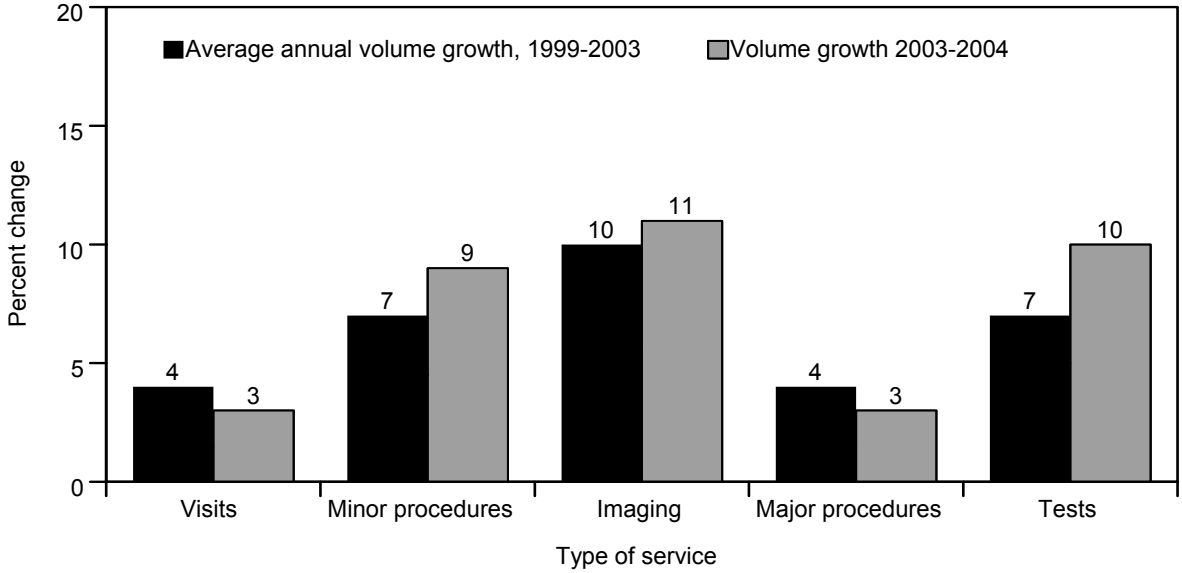
- Physician services can be classified by type of service. The visit category consists primarily of office visits but also includes consultations and visits to patients in facility settings. Procedures include major procedures such as open heart surgery, joint replacement, and back surgery and minor procedures such as colonoscopy, knee arthroscopy, and various eye procedures. Imaging includes x-rays of the chest, the musculoskeletal system, and other parts of the body as well as more advanced procedures, such as computed tomography and magnetic resonance imaging (MRI). Tests range from laboratory specimen analysis to electrocardiograms and cardiovascular stress tests. Part B drugs consist of covered drugs furnished in physician offices.

- Growth in spending for physician services varies by type of service. Between 2004 and 2005, growth was highest for imaging services and other services (e.g., supplies and equipment furnished incident to physicians' services and medical nutritional therapy).

- Spending on Part B drugs decreased between 2004 and 2005. CMS attributes much of the decrease to changes in Medicare's payment methodology.

- CMS attributes most of the overall rise in spending to growth in the volume and intensity of services.

Chart 8-5. Volume grew more rapidly in 2004 than in previous years



Note: Volume is measured as the units of service multiplied by each service's relative weight (relative value units) from the physician fee schedule. The measure thus accounts for changes in both the number of services and the complexity, or intensity, of those services.

Source: MedPAC analysis of claims for 100 percent of Medicare beneficiaries in 1999–2004.

- Across all services, volume grew 6.2 percent between 2003 and 2004. This growth is higher than the average annual volume growth of 5.4 percent seen between 1999 and 2003. Per capita volume for imaging grew the most. From 2003 to 2004, the imaging volume growth rate was 11.0 percent.

- These estimates include only services paid for under the physician fee schedule. The estimates would be higher if they included the volume of other services in CMS's broader definition of physician services, such as Medicare Part B drugs and laboratory services. The Commission had found, for example, that volume of chemotherapy drugs increased 12 percent from 2003 to 2004 and erythropoietin (for patients with end-stage renal disease) grew 36 percent.

- Volume growth for visits may be constrained by their greater dependence on actual physician time, compared with imaging and procedure-based services, which may rely more heavily on the aid of technology and nonphysician practitioners. Major surgical procedures are considerably less discretionary, and in some cases may be replaced by medical treatments or other procedures.

- It is not clear whether volume growth contributes to better health outcomes.

Chart 8-6. Medicare Economic Index input categories, weights, and projected price changes for 2007

Input component	Category weight	Price changes for 2007
Total	**100.0%**	**3.7%**
Physician work	**52.5**	**3.7%**
Wages and salaries	42.7	3.5
Fringe benefits (nonwage compensation)	9.7	4.5
Physician practice expense	**47.5**	**3.8**
Nonphysician employee compensation:	18.7	3.8
Wages and salaries	13.8	3.5
Fringe benefits (nonwage compensation)	4.8	4.6
Office expense	12.2	2.0
Professional liability insurance	3.9	8.6
Medical equipment	2.1	1.2
Drugs and supplies:	4.3	3.9
Pharmaceuticals	2.3	4.9
Medical materials and supplies	2.0	2.5
Other professional expense	6.4	2.4

Note: Forecasted price changes for individual components are calculated by multiplying the component's weight by its price proxy. Forecasted price changes are not adjusted for productivity. Numbers may not sum to 100 percent due to rounding.

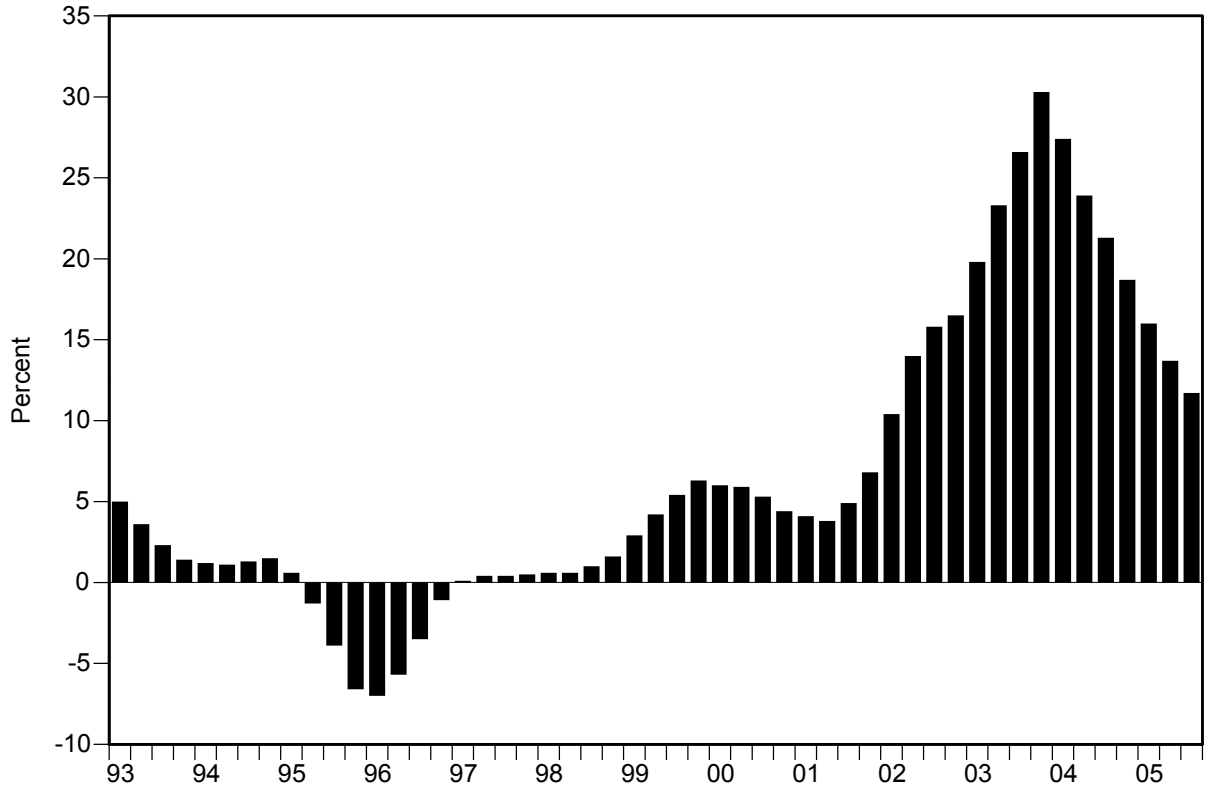
Source: Unpublished estimates from CMS, dated December 7, 2005.

- An important factor in determining the payment update for physician services is the projected change in input prices for physician services as measured by the Medicare Economic Index (MEI). The MEI is a weighted average of price changes for physician time and effort (i.e., work) and practice expense.

- CMS projects that input prices for physician work will increase 3.7 percent in 2007, based on increases of 3.5 percent in wages and salaries and 4.5 percent in nonwage compensation. Practice expenses are projected to increase 3.8 percent. This projection primarily reflects a 3.8 percent increase in nonphysician employee compensation and a 2.0 percent increase in office expenses.

- Professional liability insurance has the largest projected price change, 8.6 percent.

Chart 8-7. Quarterly changes in professional liability insurance premiums, 1993–2005

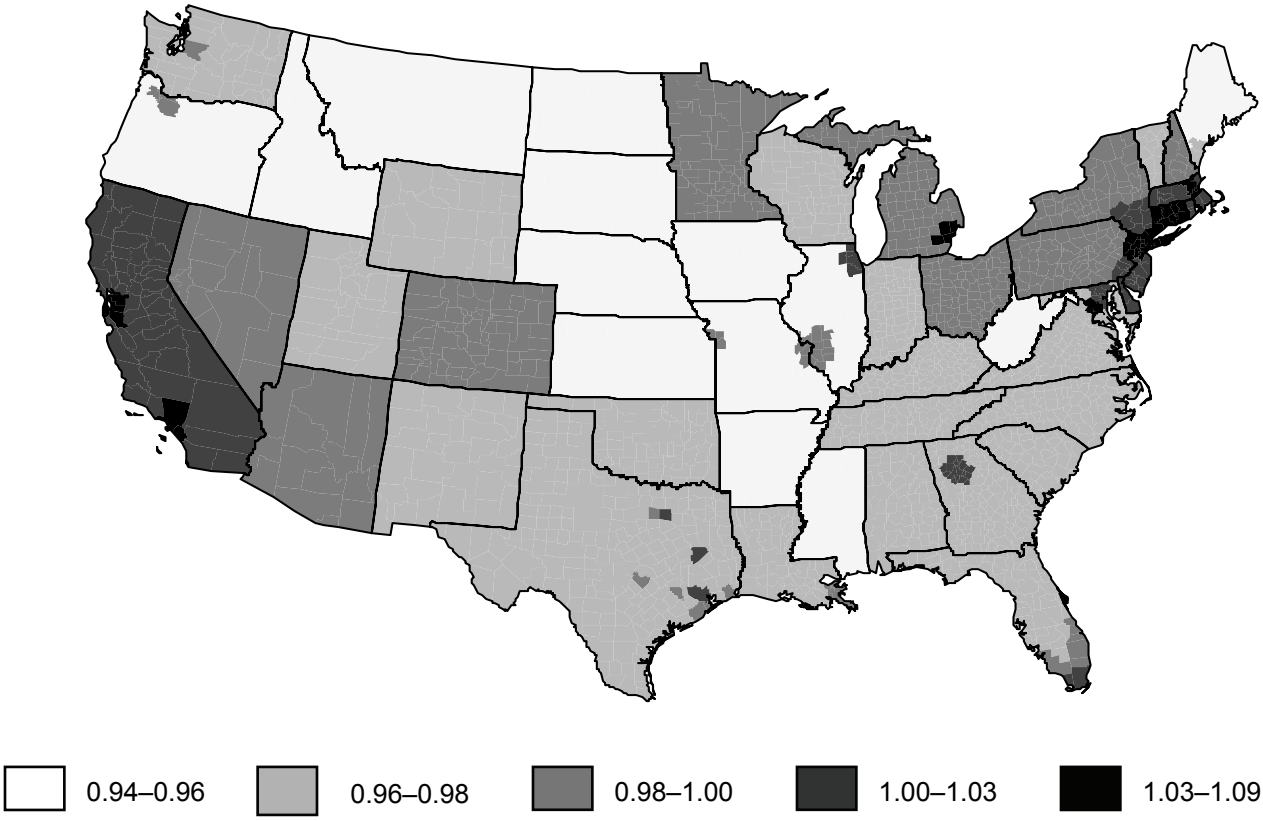


Source: MedPAC analysis of unpublished data from CMS.

- Historically, the professional liability insurance (PLI) component of the Medicare Economic Index followed a strong cyclical pattern, illustrated by the changes in PLI premiums from 1993 to 2001. The cycle was generally characterized by periods of low premiums, perhaps when insurers were building market share, and high premiums, perhaps when insurers were building reserves.

- Since 2001, changes in PLI premiums have departed from this cyclical pattern. The increase in the fourth quarter of 2003, estimated at 30.3 percent, was the highest in over a decade. Since then, change in PLI premiums has slowed, falling to 11.7 percent in the third quarter of 2005, but still remains greater than in the pre-2001 period.

Chart 8-8. Work GPCI before the MMA established a floor of 1.00



Note: GPCI (geographic practice cost index), MMA (Medicare Prescription Drug, Improvement, and Modernization Act of 2003).

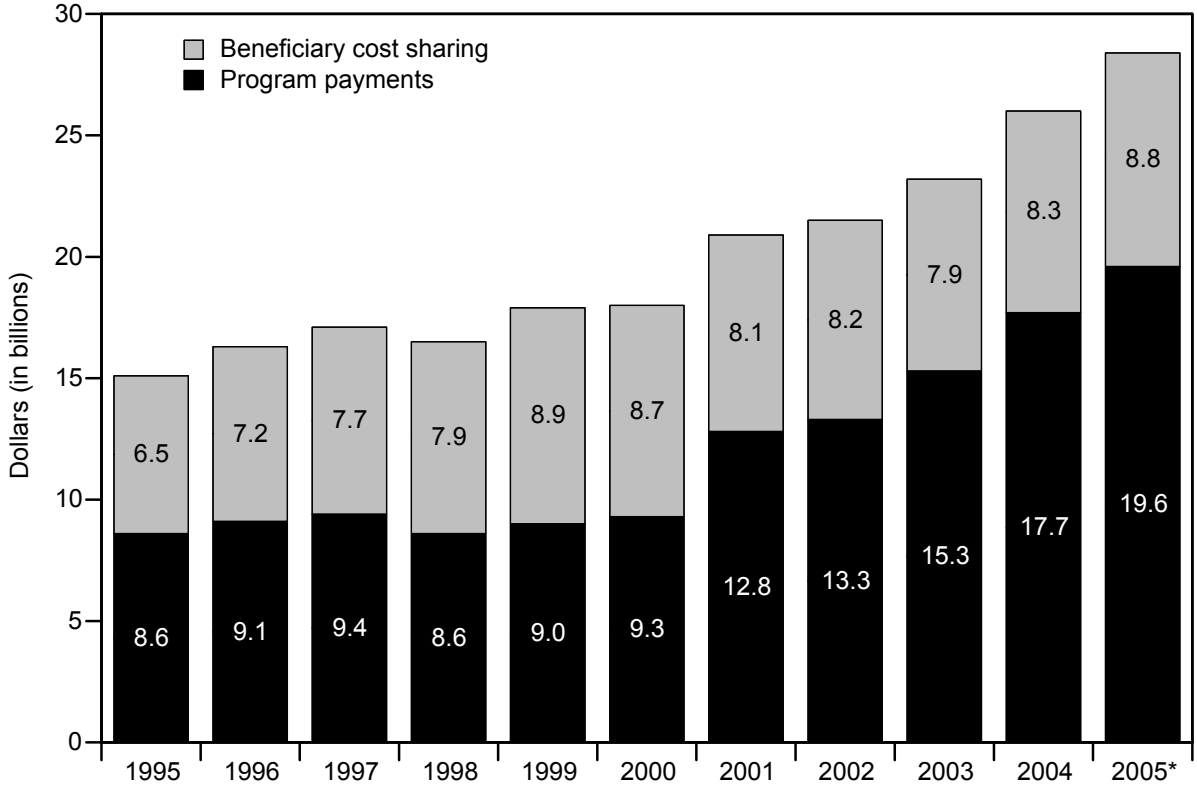
Source: Geographic practice cost index from CMS.

- Under Medicare's physician fee schedule, geographic practice cost indexes (GPCIs) adjust payment rates to account for differences in the price of inputs used in furnishing physician services. There are three GPCIs, one corresponding to each component of the relative value scale: physician work, practice expense, and professional liability insurance (PLI). The three GPCIs are applied to determine rates for each of 89 payment areas. Of the 89 areas, 34 are statewide.

- Prior to the implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the work GPCI ranged from 0.94 to 1.09. The MMA temporarily reduced this variation by establishing a three-year floor for the work GPCI of 1.00.

- The work GPCI floor will expire on December 31, 2006, at which point it is expected that work GPCIs will again vary widely across the 89 payment areas nationwide.

Chart 8-9. Spending on all hospital outpatient services, 1995–2005



Note: Spending amounts are for services covered by the Medicare outpatient prospective payment system and those paid on separate fee schedules (e.g., ambulance services or durable medical equipment) or those paid on a cost basis (e.g., organ acquisition or flu vaccines). They do not include payments for clinical laboratory services.
* Estimate.

Source: CMS, Office of the Actuary.

- Overall spending by Medicare and beneficiaries on hospital outpatient services (excluding clinical laboratory services) almost doubled from calendar year 1995 to 2005, reaching $28.4 billion. The Office of the Actuary projects continued growth in total spending, averaging 7.5 percent per year from 2002 to 2007.

- A prospective payment system (PPS) for hospital outpatient services was implemented in August 2000. Services paid under the outpatient PPS represent about 90 percent of spending on all hospital outpatient services.

- In 2001, the first full year of the outpatient PPS, spending under the PPS was $19.2 billion, including $11.4 billion by the program and $7.7 billion in beneficiary cost sharing. By 2005, spending under the outpatient PPS is expected to rise to $25.9 billion ($17.6 billion program spending; $8.3 billion beneficiary copayments). The outpatient PPS accounted for about 5 percent of total Medicare spending by the program in 2005.

- Beneficiary cost sharing under the outpatient PPS is generally higher than for other sectors, about 32 percent in 2005. Chart 8-13 provides more detail on coinsurance.

Chart 8-10. Most hospitals provide outpatient services

Year	Hospitals	Percent offering		
		Outpatient services	Outpatient surgery	Emergency services
1991	5,191	92%	79%	91%
1997	4,976	93	81	92
2001	4,347	94	84	93
2002	4,210	94	84	93
2003	4,079	94	86	93
2004	3,882	94	86	92

Note: Includes services provided or arranged by short-term hospitals. Excludes long-term, Christian Science, psychiatric, rehabilitation, children's, critical access, and alcohol/drug hospitals.

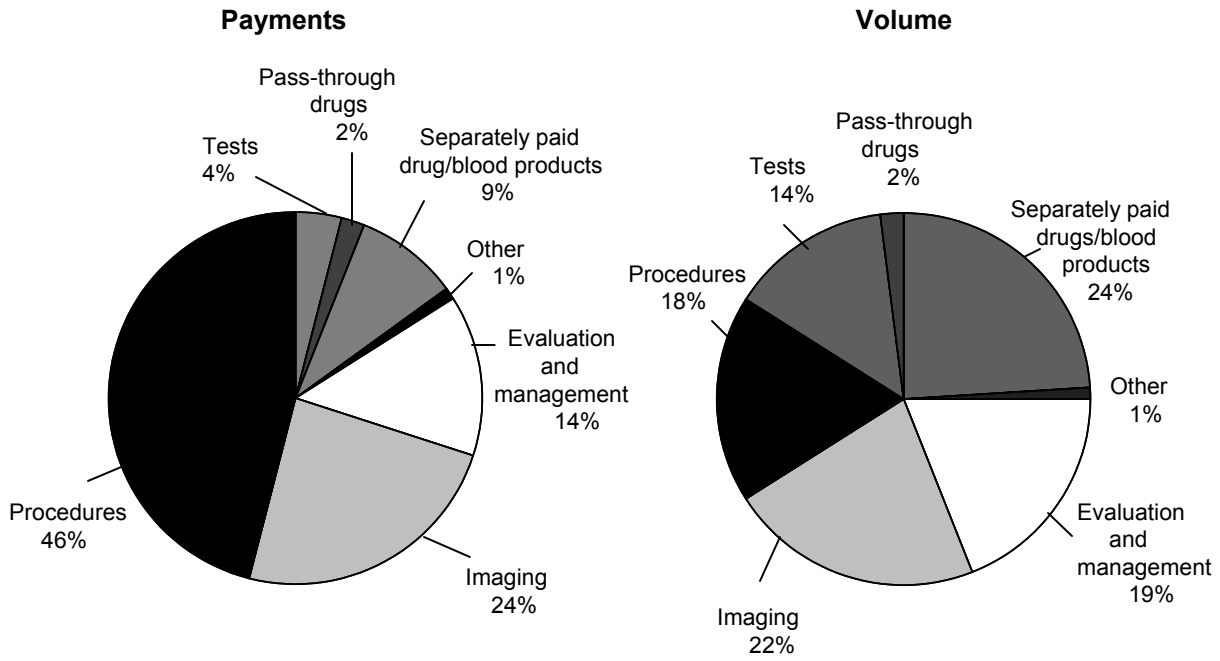
Source: Medicare Provider of Services files from CMS.

- The number of hospitals that furnish services under Medicare's outpatient prospective payment system has declined, largely due to growth in the number of hospitals converting to critical access hospital status, which allows payment on a cost basis. However, the percent of hospitals providing outpatient services and emergency services has remained stable, and the percent providing outpatient surgery has increased.

- Almost all hospitals provide outpatient (94 percent) and emergency (92 percent) services. The vast majority (86 percent) provide outpatient surgery.

- The share of hospitals providing outpatient services did not change after the introduction of the outpatient prospective payment system.

Chart 8-11. Payments and volume of services under the Medicare hospital outpatient PPS, by type of service, 2004



Note: PPS (prospective payment system). Payments include both program spending and beneficiary cost sharing but do not include transitional corridor payments (see Chart 8-14 for further information regarding transitional corridor payments). Services are grouped into evaluation and management, procedures, imaging, tests, and other categories according to the Berenson-Eggers Type of Service classification developed by CMS. Pass-through drugs and separately paid drugs and blood products are classified by their payment status indicator. Percentages may not sum to 100 percent due to rounding.

Source: MedPAC analysis of the 100 percent special analytic file of outpatient PPS claims for 2004 from CMS.

- The volume of services is distributed differently than payments. For example, procedures account for 18 percent of the volume, but 46 percent of the payments.
- Hospitals provide many different types of services in their outpatient departments, including emergency and clinic visits, imaging and other diagnostic services, laboratory tests, and ambulatory surgery.
- Over 40 percent of the services provided in hospital outpatient departments are evaluation and management or imaging services.
- Procedures (e.g., endoscopies, surgeries, skin and musculoskeletal procedures) account for the greatest share of spending on services (46 percent), followed by imaging services (24 percent), and evaluation and management (14 percent).
- In 2004, separately paid drugs and blood products accounted for 9 percent of spending.

Chart 8-12. Hospital outpatient services with the highest Medicare expenditures, 2004

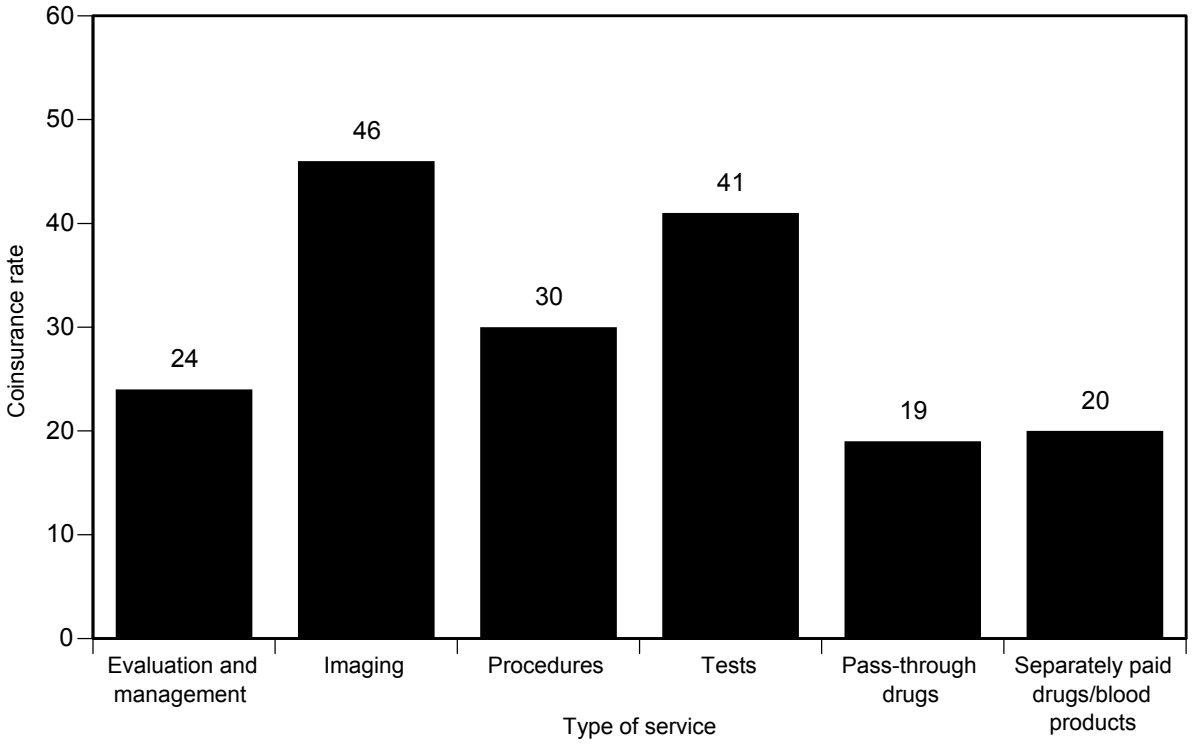
APC	Title	Share of payments
Total		48
0610, 0611, 0612	All emergency visits	7%
0600, 0601, 0602	All clinic visits	4
0246	Cataract procedures with IOL insert	4
0283	CT with contrast material	4
0080	Diagnostic cardiac catheterization	3
0260	Level I plain film except teeth	3
0143	Lower gastrointestinal endoscopy	3
0332	CT and computerized angiography without contrast material	3
0301	Level II radiation therapy	3
0336	MRI and magnetic resonance angiography without contrast	2
0337	MRI and magnetic resonance angiography without contrast material followed by contrast material	2
0280	Level III angiography and venography except extremity	2
0141	Upper gastrointestinal procedures	2
0120	Infusion therapy except chemotherapy	1
0325	Group psychotherapy	1
0333	Computerized axial tomography and computerized angio w/o contrast material followed by contrast	1
0377	Level III cardiac imaging	1
0733	Non-ESRD epoetin alpha injection, 1,000 units	1
0131	Level II laparoscopy	1
0267	Level III diagnostic ultrasound except vascular	1
0154	Hernia/hydrocele procedures	1

Note: APC (ambulatory payment classification), IOL (intraocular lens), CT (computed tomography), MRI (magnetic resonance imaging), ESRD (end-stage renal disease). Payments include both program spending and beneficiary cost sharing.

Source: MedPAC analysis of the 100 percent analytic file of outpatient prospective payment system claims for calendar year 2004.

- Although the outpatient prospective payment system covers thousands of services, expenditures are concentrated in a handful of categories that have high volume, high payment rates, or both.

Chart 8-13. Medicare coinsurance rates, by type of hospital outpatient service, 2004



Note: Services were grouped into categories of evaluation and management, imaging, procedures, and tests according to the Berenson-Eggers Type of Service classification developed by CMS. Pass-through drugs and devices and separately paid drugs and blood products are classified by their payment status indicators. There is no beneficiary copayment for pass-through devices.

Source: MedPAC analysis of 100 percent special analytic file of 2004 outpatient prospective payment system claims and payment rates.

- Historically, beneficiary coinsurance payments for hospital outpatient services were based on hospital charges, while Medicare payments were based on hospital costs. As hospital charges grew faster than costs, coinsurance represented a large share of total payment over time.
- In adopting the outpatient prospective payment system, the Congress froze the dollar amounts for coinsurance. Consequently, beneficiaries' share of total payments will decline over time.
- The coinsurance rate is different for each service. Some services, such as imaging, have very high rates of coinsurance—46 percent. Other services, such as clinic visits, have coinsurance rates of 20 percent.
- In 2004, the overall coinsurance rate was about 33 percent.

Chart 8-14. Transitional corridor payments as a share of Medicare hospital outpatient payments, 2002–2004

	2002		2003		2004	
Hospital group	Number of hospitals	Share of payments from transitional corridors	Number of hospitals	Share of payments from transitional corridors	Number of hospitals	Share of payments from transitional corridors
All hospitals	3,636	2.5%	3,621	2.4%	3,368	0.9%
Urban	2,425	2.3	2,421	1.9	2,344	0.5
Rural ≤ 100 beds	933	5.8	929	7.7	768	5.4
Rural >100 beds	278	1.1	271	1.6	256	0.6
Major teaching	289	5.0	284	3.6	279	0.9
Other teaching	770	1.5	760	1.5	739	0.3
Nonteaching	2,577	2.1	2,577	2.5	2,350	1.2

Note: A small number of hospitals could not be classified due to missing data.

Source: MedPAC analysis of Medicare Cost Report files from CMS.

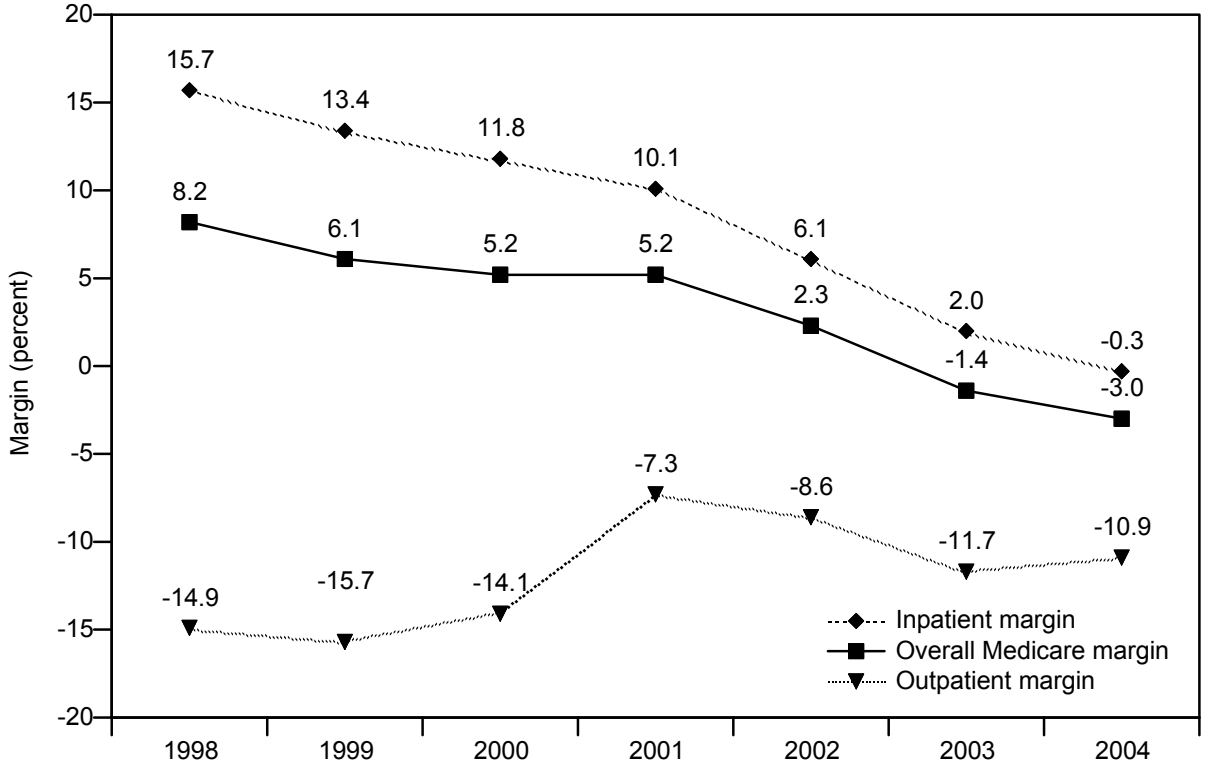
- When Medicare implemented the hospital outpatient prospective payment system (PPS) in 2000, Medicare moved from paying hospitals based on their costs to a payment schedule based on average (median) costs for all hospitals.

- Recognizing that some hospitals might receive lower payments under the outpatient PPS than they had under the earlier system, the Congress included a transition mechanism, called transitional corridor payments. The corridors were designed to make up part of the difference between payments that hospitals would have received under the old payment system and those under the new outpatient PPS. To provide incentives for efficiency, Medicare did not compensate the full difference, except for rural hospitals with 100 or fewer beds, cancer hospitals, and children's hospitals.

- Transitional corridor payments represented 2.5 percent of total outpatient PPS payments in 2002, declining to 2.4 percent in 2003, then to 0.9 percent in 2004. The decline from 2003 to 2004 is due to the expiration of transitional corridor payments for most hospitals on December 31, 2003. However, the payments continued for two more years—through December 31, 2005—for rural sole community hospitals and other rural hospitals with 100 or fewer beds. The Deficit Reduction Act of 2005 extended most of the transitional corridor payments for rural hospitals with 100 or fewer beds through December 31, 2008.

- In 2004, rural hospitals with 100 or fewer beds received 5.4 percent of their payments from transitional corridor payments.

Chart 8-15. Medicare hospital outpatient, inpatient, and overall Medicare margins, 1998–2004



Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs. Analysis excludes critical access hospitals. Overall Medicare margins cover the costs and payments of hospital inpatient, outpatient, psychiatric and rehabilitation (not paid under the prospective payment system), skilled nursing facilities, and home health services, as well as graduate medical education.

Source: MedPAC analysis of Medicare cost report data from CMS.

- Hospital outpatient margins vary. In 2004, while the aggregate margin was –10.9 percent, 25 percent of hospitals had margins of –21.2 percent or lower, and 25 percent had margins of –1.8 percent or higher.

- Given hospital accounting practices, margins for hospital outpatient services must be considered in the context of Medicare payments and hospital costs for the full range of services provided to Medicare beneficiaries. Hospitals allocate overhead to all services, so we generally consider costs and payments overall.

- The improvement in outpatient margins from 1999 to 2001 is consistent with policies implemented under the outpatient prospective payment system that increased payments. Margins declined somewhat from 2001 to 2003. This may reflect the decline in the number of drugs and devices eligible for pass-through payments. The margin improved in 2004, perhaps due to many drugs becoming specified covered outpatient drugs (SCODS). In 2004 and 2005, these drugs were paid on the basis of average wholesale price, which increased their payment rates. These additional payments were not budget neutral, so aggregate outpatient payments increased.

Chart 8-16. Number of Medicare-certified ASCs increased over 60 percent, 1999–2005

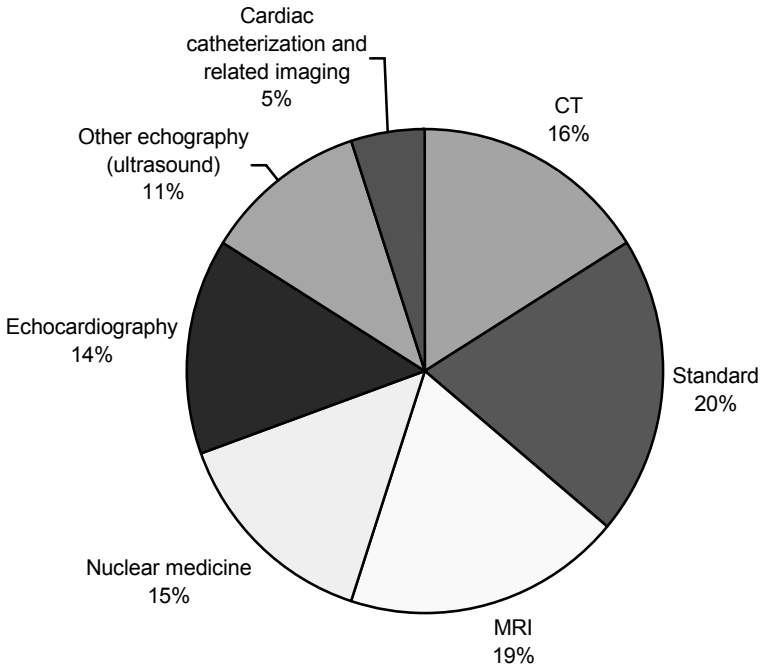
	1999	2000	2001	2002	2003	2004	2005
Medicare payments (billions of dollars)	$1.2	$1.4	$1.6	$1.9	$2.2	$2.5	$2.8
Number of centers	2,786	3,028	3,371	3,597	3,887	4,136	4,506
New centers	162	295	446	309	365	315	467
Exiting centers	20	53	103	83	75	66	97
Net percent growth from previous year	5.4%	8.7%	11.3%	6.7%	8.1%	6.4%	8.9%
Percent of all centers that are:							
For profit	94	94	94	95	95	96	96
Nonprofit	6	6	5	5	5	4	4
Urban	89	88	88	87	87	87	87
Rural	11	12	12	13	13	13	13

Note: ASC (ambulatory surgical center), N/A (not available). Medicare payments include program spending and beneficiary cost sharing for ASC facility services. Payments for 2005 are preliminary and subject to change. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of provider of services files from CMS, 1999–2005. Payment data from CMS, Office of the Actuary.

- Ambulatory surgical centers (ASCs) are entities that only furnish outpatient surgical services not requiring an overnight stay. To receive payments from Medicare, ASCs must meet Medicare's conditions of coverage, which specify minimum facility standards.
- Medicare uses a simple fee schedule to pay for ASC services. The fee schedule divides procedures into nine payment groups. CMS is required to implement a revised payment system no later than January 1, 2008.
- Total Medicare payments for ASC services are growing rapidly. Payments increased by 15.3 percent per year, on average, from 1999 through 2005.
- The number of Medicare-certified ASCs grew at an average annual rate of 8.3 percent from 1999 through 2005. Each year from 1999 through 2005, an average of 337 new Medicare-certified facilities entered the market, while an average of 71 closed or merged with other facilities.
- Most Medicare-certified ASCs are for-profit facilities and are located in urban areas.

Chart 8-17. Medicare spending for imaging services, by type of service, 2004



Note: CT (computed tomography), MRI (magnetic resonance imaging). Cardiac catheterization includes placement of the catheter and the related imaging procedure, such as an angiogram. Medicare payments include program spending and beneficiary cost sharing for physician fee schedule imaging services.

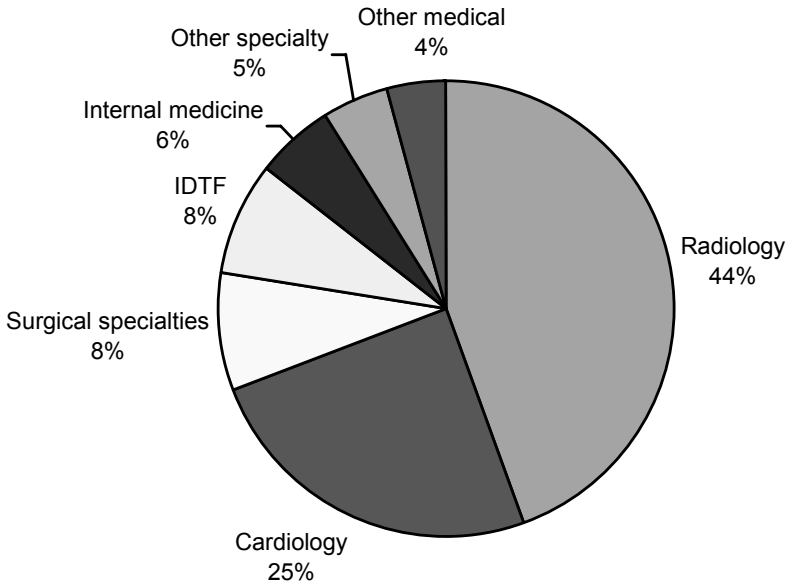
Source: MedPAC analysis of 100 percent physician/supplier procedure summary file from CMS, 2004.

- Medicare spending for imaging services paid under the physician fee schedule nearly doubled between 1999 and 2004, from $5.7 billion to $10.9 billion.

- The volume and complexity of imaging services grew by 9.9 percent per year, on average, between 1999 and 2003—nearly twice as fast as all physician services (5.4 percent per year). Imaging increased 11 percent from 2003 to 2004. These growth rates are adjusted for increases in the number of fee-for-service beneficiaries and changes in payment rates.

- Spending for MRI, CT, and nuclear medicine has grown faster than for other imaging services. Thus, these categories represent an increasing share of total imaging spending. MRI spending grew by 162 percent between 1999 and 2004, nuclear medicine by 145 percent, and CT by 118 percent.

Chart 8-18. Radiologists received almost half of Medicare payments for imaging services, 2004



Note: IDTF (independent diagnostic testing facility). Medicare payments include program spending and beneficiary cost sharing for physician fee schedule imaging services. Total fee schedule imaging spending was $10.9 billion in 2004. Other specialty includes otolaryngology, pain management, osteopathic, physical medicine, nephrology, podiatry, cardiac surgery, oncology, and portable x-ray supplies.

Source: MedPAC analysis of 100 percent physician/supplier procedure summary file from CMS, 2004.

- Imaging services paid under the physician fee schedule involve two parts: the technical component, which covers the cost of the equipment, supplies, and nonphysician staff, and the professional component, which covers the physician's work in interpreting the study and writing a report. A physician who both performs and interprets the study submits a global bill, which includes the technical and professional components.

- Independent diagnostic testing facilities (IDTFs) are independent of a hospital and physician office and only provide outpatient diagnostic services. IDTFs' share of Medicare imaging payments grew by 6 percent from 2003 to 2004. Medicare pays for IDTF services under the physician fee schedule at the same rates as services provided in physician offices.

Web links. Ambulatory care

Physicians

- For more information on Medicare's payment system for physician services, see MedPAC's Payment Basics series.

  http://www.medpac.gov/publications/other_reports/Dec05_payment_basics_physician.pdf

- Chapter 2B of the MedPAC March 2006 Report to the Congress and Appendix A of the June 2006 Report to the Congress provide additional information on physician services.

  http://www.medpac.gov/publications/congressional_reports/Mar06_Ch02b.pdf
  http://www.medpac.gov/publications/congressional_reports/Jun06_AppA.pdf

- More information on physician volume growth can be found in MedPAC's December 2004 report.

  http://www.medpac.gov/publications/congressional_reports/Dec04_PhysVolume.pdf

- Congressional testimony by the Chairman and Executive Director of MedPAC on February 10, 2005, March 17, 2005, and November 17, 2005, discusses payment for physician services in the Medicare program, including imaging.

  http://www.medpac.gov/publications/congressional_testimony/021005_WM_testimony.pdf

  http://www.medpac.gov/publications/congressional_testimony/031705_TestimonyImaging-Hou.pdf

  http://www.medpac.gov/publications/congressional_testimony/Testimony_111705_Phys_Pay.pdf

- The 2006 Annual Report of the Boards of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds provides details on historical and projected spending on physician services.

  http://www.cms.hhs.gov/ReportsTrustFunds/

Hospital outpatient services

- For more information on Medicare's payment system for hospital outpatient services, see MedPAC's Payment Basics series.

  http://www.medpac.gov/publications/other_reports/Dec05_payment_basics_OPD.pdf

- Section 2A of the MedPAC 2006 Report to the Congress provides information on the current status of "hold-harmless" payments and other special payments for rural hospitals.

  http://www.medpac.gov/publications/congressional_reports/Mar06_Ch02a.pdf

- Chapter 3A of the MedPAC March 2004 Report to the Congress provides additional information on hospital outpatient services, including outlier and transitional corridor payments.

  http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3A.pdf

- A description of coinsurance under the outpatient PPS can be found in Chapter 9 of the MedPAC March 2001 Report to the Congress.

  http://www.medpac.gov/publications/congressional_reports/Mar01%20Ch9.pdf

- More information on new technology and pass-through payments can be found in Chapter 4 of the MedPAC March 2003 Report to the Congress.

  http://www.medpac.gov/publications/congressional_reports/Mar03_Ch4.pdf

Ambulatory surgical centers

- For more information on Medicare's payment system for ambulatory surgical centers, see MedPAC's Payment Basics series.

  http://www.medpac.gov/publications/other_reports/Dec05_payment_basics_ASC.pdf

- Chapter 3F of the MedPAC March 2004 Report to the Congress provides additional information on ambulatory surgical centers.

  http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3F.pdf